

Community Reinforcement and the Dissemination of Evidence-based Practice: Implications for Public Policy

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Abstract

The Community Reinforcement Approach (CRA) and Community Reinforcement and Family Training (CRAFT) are both highly effective and empirically validated psychosocial approaches to the treatment of addictions whose unique designs may help achieve certain public health objectives. Literature will be reviewed to examine the potential impact of CRA and CRAFT on the dissemination of evidenced-based practice at a public policy level. Through developing relationships with one another, practitioners, social scientists and policy makers may find that they can assist each other in advancing public health through the de-stigmatization of addictions and the promotion of evidence-based practices. Keywords: Community Reinforcement, public policy, dissemination

Overview

Public policy may not be regarded as the purview of many social science or psychotherapy researchers, though many are beginning to consider the benefits of such a partnership. This paper will explore the ways in which the principles and practices of “community reinforcement” are consistent with many of the concerns of public health and public policy. We will specifically focus upon two empirically-validated approaches to treating addictions based upon the theory of community reinforcement: the Community Reinforcement Approach (CRA; Hunt & Azrin, 1973; Meyers & Smith, 1995) and Community Reinforcement and Family Training (CRAFT; Meyers & Wolfe, 2004; Smith & Meyers, 2004). Unfortunately, the existence of evidence-based treatments for addictions such as CRA and CRAFT does not guarantee that these treatments will reach the individuals with the greatest need for them. In fact, the magnitude of the problem of disseminating empirically-supported treatments has only begun to be realized in recent years.

The following includes a discussion of the practice of dissemination at the policy level and some research that supports strategies of collaboration and relationship development between researchers and policy makers. Working together, researchers and policy makers may be able to more effectively address sociopolitical issues related to substance abuse treatment, such as the widespread practice of incarcerating substance users in place of providing empirically-supported treatment. Evidence will also be shown that both CRA and CRAFT are ideal “candidates” for dissemination for a variety of reasons. One primary reason is that they are applicable across many populations and cultures, thereby making these approaches even more viable from a public health perspective. Finally, we will direct our focus on the problem of stigmatization of mental disorders, particularly addictions, and discuss how community reinforcement may also be useful in contextualizing and treating addictions beyond the level of the individual alone.

Mental Health on the National Agenda

Mental health issues gained national attention in the United States with the publication of the Surgeon General’s first report on mental health in 1999 (U.S. Department of Health and Human Services, 1999). This report represents a challenge for the nation to acknowledge and implement the array of mental health treatments that have been supported by scientific evidence. To achieve best practices in

mental health, the Surgeon General's report specifically promotes a public health approach, which is one that adheres to a broad-based focus on psychosocial environment, as well as individualized diagnosis and treatment (Miller & Brown, 1997). The American Psychological Association (APA) also took up the cause of promoting scientifically proven treatments by creating a task force to study the problem. The resulting report did not limit the definition of evidence-based practice to that which was scientifically supported, but added that it should encompass "the context of patient characteristics, culture, and preferences" as well (APA, 2005).

Community Reinforcement

The first community reinforcement based treatment to gain support was the Community Reinforcement Approach (CRA), which now stands as one of the most highly effective treatments for alcoholism (Finney & Monahan, 1996; Miller & Wilbourne, 2002). CRA is also effective in treating cocaine use disorders, particularly when used in combination with contingency management (Higgins & Abbott, 2001; Roozen et al., 2004). Consistent with a public health model of mental health, this psychosocial approach is rather unique among treatments in that it is designed to address the individual within the environmental context in which problematic drug or alcohol use occurs, as well as the psychological mechanisms that are involved in the maintenance of the addiction. By working to increase the rewarding effects of the social, vocational, and familial aspects of patients' lives, CRA seeks to help individuals create non-using lifestyles that are more rewarding than lifestyles involving drugs or alcohol (Hunt & Azrin, 1973; Meyers & Smith, 1995). CRA lives up to the standard of care for mental health services promoted by the Surgeon General's Report on Mental Health and the APA's Presidential Task Force Report, as it has been ranked near the top of a list of 46 different treatment modalities for alcohol problems (Miller & Wilbourne, 2002). Additionally, an earlier cost-effectiveness review ranked CRA first in a list of 24 treatments for alcoholism, and labeled CRA's cost as "medium-low" when compared to other treatments (Finney & Monahan, 1996).

From a client's perspective, it is also easier to understand and commit to a treatment that focuses not just on their substance use, but gives equal weight to a variety of other important areas of life. One way in which CRA accomplishes this is through the use of the Happiness Scale, a brief questionnaire that clients complete in order to convey their satisfaction in multiple life areas: substance use, job/educational progress, money management, social life, personal habits, marriage/family relationships, legal issues, emotional life, communication, and spiritually (Meyers & Smith, 1995). Unlike many traditional approaches rooted in the disease model of addiction (Moyers & Miller, 1993), community reinforcement works with the client to develop a unique, reasonable treatment objective. The "sobriety sampling" procedure within CRA allows clients to decide (with guidance) what a manageable period of abstinence might be. When successful in achieving the negotiated period of nonuse, clients begin to experience the positive effects of a sober lifestyle, such as support from family members and increased self-confidence, which leads to enhanced motivation for therapeutic work.

Community Reinforcement and Family Training (CRAFT) is an extension of CRA that works with the family members of individuals who have a substance use disorder but who adamantly refuse to seek treatment. CRAFT's aim is to help family members alter their daily interactions with their treatment-refusing loved one, such that the substance user is more likely to enter treatment (Meyers & Wolfe, 2004; Smith & Meyers, 2004). Like CRA, CRAFT focuses on the environmental context of substance use. CRAFT helps family members rearrange their loved one's contingencies, so that a drug-free lifestyle is rewarded with increased familial, social and vocational opportunities (Smith & Meyers, 2004). CRAFT has gained more empirical support than any other treatment that works with family members without the substance abuser present (Meyers, Miller, Hill, & Tonigan, 1999; Meyers, Miller, Smith & Tonigan, 2002; Miller, Meyers, & Tonigan, 1999).

Public Policy and the Dissemination of Evidence-Based Practice

Despite the demonstrated efficacy of community reinforcement, both CRA and CRAFT, along with a host of other empirically supported treatments, are not widely used. In response to decades of treatment research and the recent momentum gained by attention from APA and the nation's highest office of health, a "science of dissemination" has emerged that seeks to bridge the gap between research and practice (Kerner, Rimer, & Emmons, 2005; Schoenwald & Henggeler, 2004). For dissemination and subsequent diffusion efforts to be effective, it is increasingly evident that these efforts must go beyond raising individual awareness of evidence-based practices and reach systemic levels of adoption (Miller, Sorensen, Selzer, & Brigham, 2006). Public policy is one strategy for dissemination that has been shown to be effective in the promotion of public health. Perhaps this has been most prominent with regard to the success of tobacco control, beginning with the 1964 Surgeon General's report on smoking and health (UDHHS, 1964). Increasingly, both mental health researchers (Jackson-Elmoore, 2005; Stirman, Crits-Christoph, & DeRubeis, 2004) and addiction researchers (Morgenstern, Morgan, McCrady, Keller, & Carroll, 2001; Sobell, 1996; Walters, Matson, Baer, & Ziedonis, 2005) are recognizing the complexities of dissemination, and thus are beginning to investigate various strategies for doing so. A subset of researchers also advocate for population-based public health approaches as potentially being more comprehensive and effective than treating addiction simply on an individual basis (Room, Babor, & Rehm, 2005).

Effective models for disseminating evidence-based practice among addictions providers in Canada have been described by Martin, Herie, Turner, and Cunningham (1998) and Sobell (1996). A key aspect for these researchers was to work both within and outside the targeted treatment system with an eye for both public and political pressures. As such, Martin and colleagues (1998) formed an External Advisory Committee composed of consumer, treatment provider, and government stakeholders to guide their dissemination process. Focus groups were held to promote collaboration between many areas of the community, including hospitals, social services, and correctional services. Sobell (1996) also describes the creation of a multidisciplinary team of individuals who were treated as full collaborators in the dissemination process. The authors of both of these studies attributed their success partly to the cooperative atmosphere that these strategies engendered.

Working cooperatively alongside policy makers may be especially beneficial in garnering the necessary structural and financial support from community, state, and nationwide government that is so important in promoting and sustaining evidence-based practices on a large-scale (Miller et al., 2006; Stirman et al., 2004). Very little research has been done on the interface between research and public policy making, though one study has shown that, when queried, public health decision-makers consider research an important source of information. However, this same study demonstrated that decision-makers did not have a solid understanding of research, nor were researchers adept at disseminating research results (Tomson et al., 2005). One method to overcome these barriers to dissemination is to document sources of information that legislators use, and examine those information sources differentially by legislator and district characteristics (Jackson-Elmoore, 2005). Presumably, this will allow practitioners and researchers to target their dissemination efforts more precisely, and in ways that increase the potential that information will be conveyed.

Knowing the best strategies for introducing a new treatment to policy makers and a community of counselors is critical for effective dissemination, and yet there is evidence that characteristics of the treatment itself play a significant role in its adoption into practice as well. Rogers (1995) wrote about this general issue of "technology transfer" years ago, and outlined five specific attributes of innovations that favor their adoption. Arguably CRA and CRAFT meet these requirements, and thus a brief review of them follows:

(1) *Relative advantage* is the perception that the innovation is better than the status quo. As an example, consider the advantage that CRAFT offers to the loved ones of treatment refusing substance abusers. Previous options for these family members were Al-Anon, which teaches loving detachment, or the Johnson Institute intervention; the uncomfortable “surprise party” (Barber & Gilbertson, 1997).

Importantly, *therapists* recognize the value in having these options for their clients, and thus CRAFT is often experienced by counselors as a program that offers a true advantage over the limited existing ones.

(2) *Compatibility* is a measure of the degree to which an innovation clashes with a clinician’s current practices. Just one example of how CRA is compatible with, for example, traditional 12-step programs, is the use of the CRA procedure called “Systematic Encouragement”. This behavioral technique for encouraging clients to follow through with commitments to sample new activities was actually shown to significantly increase the likelihood that a client would attend a 12-step meeting (Sisson & Mallams, 1981).

(3) *Complexity* refers to how difficult the innovation is to understand and use. Perhaps the best support for the idea that CRA and CRAFT are not unusually complex to master comes from the studies that consistently show the absence of any therapist effects (Miller & Meyers, 2001).

(4) *Trialability* represents the extent to which an innovation can be tested on a trial basis. This construct readily “fits” CRA, as therapists (and their clients) are regularly encouraged to “sample” aspects of the CRA program to see if they are comfortable with them.

(5) *Observability* implies the degree to which the outcome of the innovation can be observed. The most dramatic example of this is the engagement of a treatment-refusing individual into treatment via the CRAFT program.

Mental Health and the Criminal Justice System: Possibilities for Partnership

Finding common ground among multiple disciplines may be an important strategy for the dissemination of empirically-based addiction treatment. If properly approached, researchers, policy makers and practitioners may find that their similar interests in promoting the well-being of the public make them uncommonly good partners in achieving their objectives (Tanenbaum, 2006). This may be particularly true when it comes to complex societal problems that involve numerous systems. For instance, one of the biggest problems perplexing our policy makers and mental health professionals alike is the high rate of incarceration of citizens who are mentally ill (Lamberg, 2004). In 2005, the Bureau of Justice Statistics within the Department of Justice found that over half of all incarcerated persons had a mental health problem, and that over half of jail and prison inmates had substance use disorders.

There is empirical evidence that drug treatment received in the community or while incarcerated can reduce crime and recidivism (Jofre-Bonet & Sindelar, 2001). Specifically, a longitudinal study of county jail inmates found that treatment provided in jail worked to reduce recidivism and arrests, and saved the county over \$1 million (Turley, Thornton, Johnson, & Azzolino, 2004). A nationally representative study of state inmates indicates that about half of male prisoners and about 70% of female prisoners could benefit from some level of substance use treatment, though only a small minority actually receive any treatment services during their incarceration (Belenko & Peugh, 2005). This study goes further to identify other health and social problems common in state prisoners, such as unemployment and disturbed familial and social relationships, and shows that these problems are correlated with the severity of drug use. It may therefore be important to address multiple contextual factors that impact relapse to drug use, particularly for more severely addicted inmates.

There is a trend toward increased involvement of the criminal justice system in mental health service delivery (Wilson & Draine, 2006), and community reinforcement may be a logical choice for

addiction treatment in this population. Substance users, and particularly those who are incarcerated (or who have been), are among some of the most socially marginalized and stigmatized groups, and they generally find their way into treatment (and possibly the criminal justice system) partly as a result of experiencing a breakdown of relationships in multiple life areas (Room, 2005). Thus, in addition to reducing substance use and psychological symptoms of addiction, community reinforcement's broad contextual focus may help incarcerated, or formerly incarcerated individuals rebuild their lives to include rewarding work and recreational activities, as well as the meaningful family and social relationships that underpin those activities and promote sustained recovery from addiction (Meyers & Smith, 1995). It is promising that community reinforcement has been shown to be effective in another vulnerable, chronic population: the homeless (Smith, Meyers, & Delaney, 1998). In addition, community reinforcement has demonstrated efficacy across a variety of populations with varying cultures and socioeconomic circumstances.

Community Reinforcement and Ethnic Minority Populations

Community reinforcement's focus upon the unique contextual factors contributing to each individual's substance use makes it a flexible and adaptable approach that is sensitive to the distinct needs of ethnically and culturally diverse clients. Community reinforcement seeks to help individuals live a rewarding clean and sober life within their *own* community and cultural context (Meyers & Smith, 1995). A special strength of community reinforcement is that it has been tested upon diverse groups of clients. This is especially important given that so few substance abuse treatments have been validated on ethnic minority clients; a serious research gap that has been identified by the Surgeon General (USDHHS, 1999; 2001). CRA has been successfully applied to Hispanic (Abbott, Weller, Delaney, & Moore, 1998) and Native American individuals (Miller, Meyers, & Hiller-Sturmhofel 1999), and to an ethnically diverse homeless sample (Smith, Meyers, & Delaney, 1998). In addition, CRA was successfully pilot tested on a sample in Mexico (Torres, Vázquez, Medina-Mora, & Velazquez, 2005). Most recently, CRA has been applied to a sample of homeless women with comorbid diagnoses, more than half of whom identified as Hispanic or Native American (Smith, Delaney, Milford, & Austin, 2004). Like CRA, CRAFT has also garnered strong support with ethnically diverse populations, including Hispanics (Meyers et al., 2002; Miller et al., 1999) and African-Americans (Kirby, Marlowe, Festinger, Garvey, & LaMonaca, 1999).

Additionally, community reinforcement uniquely addresses the significant structural barriers ethnic minorities may experience when re-establishing their lives without drugs or alcohol. Ethnic minorities who misuse substances are more likely to be arrested and incarcerated for using and selling illicit substances than are non-Hispanic whites (Brownsberger, 2000; Iguchi, Bell, Ramchand, & Fain, 2005), which may make it even more challenging for these clients to obtain future housing and employment (London & Myers, 2006). In addition to criminal history, ethnic minority clients who misuse substances often experience barriers to wellness such as low socio-economic status, discrimination, and lack of documentation (USDHHS, 2001). While community reinforcement cannot directly address the structural factors that lead to these inequities, it is able to help each client or family build skills designed to reduce the negative impact of structural barriers. For example, CRA's job finding component helps clients implement strategies to gain access to educational and employment opportunities that they otherwise may have been unable to obtain. This component builds skills with the aim to help clients lead rewarding lives within their own community and cultural context (Meyers & Smith, 1995).

In order for empirically supported treatments to be adopted by ethnic minority communities, these treatments should reflect the needs and values of those communities (USDHHS, 2001). Many ethnic minority communities report an increased family orientation, labeled *familism*; a construct that is typically ignored by standard substance abuse treatments (see Castro & Alarcón, 2002). Importantly, community reinforcement addresses the consumer and family-based movement to involve family

members in mental health treatment. By directly utilizing family resources during treatment and recovery, both CRA and CRAFT are uniquely sensitive to a key value of many ethnic minority communities.

Expanding the Role of Practitioners and Researchers

If evidence-based psychological research and practice are to make contributions at the population level, interested psychologists must envision the possible public health implications of their work, and focus on strategies that will connect their work to the creation of public policy. McKnight, Sechrest, and McKnight (2005) believe that psychologists and other social scientists are valuable in that they have a thorough knowledge of many areas that affect the public health at large, and may become important sources for busy policy makers with little time for conducting their own independent research. In addition, the scientific tradition emphasizes theory creation to unify concepts and guide interventions. Furthermore, as has previously been done with addictions treatments, psychologists may themselves find it useful to augment the way they plan and conduct their research to include making room for partnership among multiple disciplines and varying stakeholders (Jason, 2006; Martin et al., 1998; Sobell, 1996).

Training programs may better prepare future psychologists by breaking out of the mold of simply treating mental disorders within individuals, and beginning to include more systems level paradigms. Indeed, expanding the role of clinical psychology is seen by some as a necessity if clinical psychologists are to meet the demands of the 21st century (Snyder & Elliott, 2005). Health psychology as a specialization has notably advocated for the public health role of future psychologists, particularly where it concerns contributing to public health policy (Abraham & Michie, 2005; Wardle & Steptoe, 2005). Other specializations are also beginning to offer training experiences to better prepare future psychologists for roles in public health promotion (Wohlford, Myers, & Callan, 1993; Yung, Hammond, Sampson, & Warfield, 1998).

Overcoming Stigma

Of interest to the Surgeon General, researchers, practitioners, and policy makers alike is the public's attitude toward mental illness, particularly substance use disorders, and how it should best be handled by society. Stigma is one of the most formidable obstacles to mental health care (USDHHS, 1999), and labels associated with substance problems are weighted down with moral judgment even across varying cultural contexts (Room, 2006). It is interesting to note that judgments concerning alcoholism have also varied throughout history, with certain models dominating the discourse at different times (Hester & Miller, 2003). The rising popularity of the public health model seems to be due, in part, to its ability to integrate the varying perspectives on alcohol problems, thereby honoring the contribution that each makes in understanding this very complex issue. As such, treatments such as CRA that integrate multiple life areas into treatment may address stigma by removing substance use as the sole focus of treatment, and thereby making substance use problems more easily understandable from a public health perspective.

Concluding Remarks

It is our belief that one of the greatest strengths of CRA and CRAFT is their potential to help destigmatize substance use problems by highlighting the psychosocial nature of addiction. As noted by the Surgeon General, the problem of stigma represents one of the most significant barriers to care, and possibly operates as a barrier to the dissemination of evidence-based practices among treatment providers who may focus on addiction from a moral or disease-based model (Moyers & Miller, 1993). Community reinforcement is currently one of the most efficacious treatment modalities for alcohol use disorders (Finney & Monahan, 1996; Miller & Wilbourne, 2002), and its foundation on a psychosocial theory of

addiction helps contextualize and expand the focus on a complex societal problem, making it consistent with a public health model. This may make community reinforcement particularly beneficial for some of the most vulnerable members of our society, such as mentally ill individuals in the criminal justice system. Future research should certainly test this notion. Also, considering that mental health problems and problems with the criminal justice system disproportionately affect ethnic minority populations (USDHHS, 2001; Cherry, Dillon & Rugh, 2002), it is notable that community reinforcement has been found to be effective across a variety of ethnic and cultural groups. Indeed, if psychologists and other providers are to function effectively in the changing ethnic make-up of the U.S. population, attention must be given to the cultural appropriateness of varying approaches.

Psychologists and other mental health practitioners have special skills that may position them to successfully influence public policy. Some may see fit to expand their role to include working institutionally or legislatively to achieve large-scale dissemination of evidence-based practices, especially as training programs begin to emphasize the broader perspectives of the public health model. In this paper, we have highlighted some promising examples of how to achieve such a partnership in the treatment of addictions (Martin et al., 1998; Sobell, 1996). It is our hope that the future of addictions treatment will see many more examples of rewarding relationships in this endeavor, especially among consumers, constituents, providers, and public policy makers.

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